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AUTHOR	Alfero, Charles
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ABSTRACT

This paper explores the broad definition of health in the rural context and relates it to policy, practice, and pedagogical challenges in providing access to services in rural areas. Historically, policy, practice, and teaching institutions have supported a dependency model for health service delivery, forcing rural communities to rely on urban-oriented health policy, urban-based training models, corporate or large bureaucratic service delivery structures, and specialized care incentives not easily supportable in sparsely populated areas. In New Mexico, the percentage of population over 65 in nonmetropolitan areas is 14.1 percent. Additionally, there is a 32 percent difference in income between urban and rural people in New Mexico. These retiree and income statistics translate to a lack of tax base and political voice for rural populations compared to their urban counterparts. Rural health services are inadequate and there are insufficient providers. Although a critical component of a system of services, traditional services are crisis-oriented and "fixative." That is, providers are taught to simply fix physical and emotional problems, failing to respond to the underlying causes of trauma. It is only when root problems are addressed in the community setting that the health system becomes truly effective and curative. Financing strategies should include the following objectives: developing programs that support locally "grown" and trained primary health care professionals, changing the perception that rural communities are incapable of performing complex or high-technology tasks, establishing a strong health promotion and illness prevention component, maintaining a primary care focus, and developing appropriate non-community-based relationships. This paper also addresses the role of health policy, support systems, and community development in meeting these goals. (LP)

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KEYNOTE ADDRESS

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KEYNOTE ADDRESS

PERSPECTIVES OF "HEALTH" IN THE RURAL CONTEXT

Charles Alfero – New Mexico

I. PURPOSE

There are a number of factors that affect the "health" of rural populations, differentiating their needs and conditions from those of urban dwellers. Many of these factors also serve to hamper the delivery of health services in rural areas. Rural communities have been viewed as incapable of solving health care access deficits and have become reliant on urban resources to respond to their needs. The purpose of this paper is to explore a broad definition of health in the rural context and relate it to policy, practice and pedagogical (teaching) challenges in providing access to services in rural areas. (See Figure 1) In addition, this article seeks to replace unresponsive paradigms in health care with concrete concepts to assist communities in overcoming historical deficits across the three areas of consideration: policy, practice and pedagogy.

II. OVERVIEW

First, it is important to consider the broad definition of health beyond the physical or emotional condition. "Health is a positive concept emphasizing social and personal resources as well as physical capacities. Health is created and lived by people in the settings of their everyday lives."[1] In the rural context, health is challenged for the individual in isolation of social and financial resources accessible to many in more urban locations. "The aim (of Health for all by the year 2000) is to give people a positive sense of health so that they can make full use of their physical, mental and emotional capacities."[2] Developing and optimizing scarce social and personal resources in rural areas in support of personal and community health requires creative responses, especially since demographic and socio-political conditions exacerbate efforts at problem solving and policy development.

Responses to rural health concerns have focused on relying, not on curative, but rather "fixative" measures to respond to the health needs of the individual. (Fixative is used by the author to describe a medical intervention that does not solve the underlying cause of the physical or emotional condition) In the medical context bigger and more specialized health care is often considered better as rural communities have been considered "too small and not capable of managing their own health care"[3] Thus policy, practice and teaching institutions have supported a dependency model for health service delivery in rural communities forcing them to rely on, urban-oriented health policy, urban-based training models, corporate or large bureaucratic service delivery structures and specialized care incentives not easily supportable in sparsely populated areas.

In order to best address the needs of rural populations, the three areas under discussion: policy, practice and teaching, must develop in unison to move the system from urban dependent and individual medical provider dominated models to community accountable interdisciplinary health systems. Health systems, comprised of a variety of health professionals, including social workers, mental health workers, home health providers as well as primary care providers, in turn, must work through communities to effectively respond to the health needs of its citizens.

Ultimately, it is not possible for individual providers to be accountable for the health of the population. Nor can systems, whether entrepreneurial ventures or public bureaucracies, be accountable. They are not designed to effectively address the complex needs of the individual or family. It is the community that must bear the burden of ensuring the health of the population. Policy, practice and educational systems must support this premise. (See Figure 2)

III. PROBLEM IN ASSURING RURAL ACCESS

A. Rural Populations

In the United States and other places, rural populations are older and have higher rates of poverty than more urban populations. In New Mexico for instance, the population over 65 in non-Metropolitan Statistical Area (MSA) counties as a percent of the total population in those counties is 14.1 percent. (MSAs are a designation of urban areas with populations of greater than 50,000 individuals) The percent of population over 65 in MSAs is 9.9 percent. This difference has serious implications on the health service delivery needs of these populations. U.S. Bureau of Census estimated projections between 1990 and the year 2020 show a potential increase of 56.1 percent for the population over 65 and a decrease in populations less than 44 years of age. Should the urban/rural distribution patterns for the elderly remain constant or linear, there will be a disproportionate impact on rural communities.

Similarly, the average per capita income in non-MSA county populations is $11,900 in New Mexico. In MSAs, the per capita income is over $17,000. This equates to a 32 percent difference in income between urban and rural people.[4]

These post-wage-earner and income statistics translate to a lack of tax base and political voice for rural populations compared to their urban counterparts in addition to the impacts of age and income on health status. Further, the rural poor are disbursed geographically, economically and ethnically, providing less potential for influencing policy development as a cohesive group.

Rural children suffer from inadequate levels of immunization, and pre- or perinatal care. In New Mexico, the average percent of the population receiving low-levels of pre-natal care statewide is 15.3 percent.[5] The average for MSAs is 12.3 percent. Because of lack of access to necessary primary care services, individuals may delay treatment of other conditions until they require more intense, specialized and expensive services. In New Mexico, 71 percent of all primary care physicians, 72 percent of all nurse practitioners, 73 percent of nurse mid-wives and 60 percent of physician assistants live in MSAs representing only 48 percent of the population. To receive even primary care, people must often travel impossibly long distances enduring added personal hardship. The average distance between incorporated communities (cities) in New Mexico is 70 miles. It is not unusual to travel in excess of 100 miles for health services.

All or part of 30 of New Mexico's 33 counties are designated by the federal government as having a shortage of health professionals. Only 3 of these areas are defined as urban. Of the balance of the rural population, a full one half resides in shortage areas.

The population in New Mexico rose some 16.3 percent during the 1980's. However, rural communities are gaining populations at a much lesser rate. MSAs in New Mexico grew at a rate of 32.3 percent compared with 6.6 percent in rural areas during the same time. Thus maintaining local tax resources, industrial development opportunities, other economic or resource optimization and political power bases from which to develop responsive rural health policy are also on the decline. For the first time in New Mexico history, a coalition of urban state legislators can swing proposed policy and financing legislation in favor of urban areas. This obviously has horrifying potential consequences for rural health priorities in the future.

Because of these issues, there is a perception that rural areas must be dependent on more populated and resource rich communities to sustain personal health and necessary services. This dependency drains potentially available rural resources to urban areas. To exacerbate problems, travelling away from the community for health care and other services has a negative impact on the local economy, assisting in the downward socio-economic spiralling process. Given these perspective rural "health" may be a more difficult goal to attain.

B. Health Policy and Rural Health Service Delivery

Rural health services are inadequate. There are insufficient numbers of providers. They are not appropriately financed, nor are their

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- personal needs being met. Health facilities are under-capitalized, and technology often falls behind similar urban settings both clinically and administratively.

Rural health services are fragmented. (See Figure 3) There are multiple entry points for people into an uncoordinated infrastructure that is often owned, determined, controlled and administered by corporate or governmental entities external to the community. As a result, resources that could be available for service provision in the community are diverted to urban settings in the form of administrative support or even profits that might otherwise be available for development. In many places, this has created a scenario where multiple organizations attempt to meet needs through a proliferation of unconnected "service-thin" providers, all competing for very limited public and/or private resources to support their corporate or organizational needs while only addressing categorical health problems.

Policy regarding the financing of health services has induced a shift in service delivery over time from rural to urban and from general to specialty care. Effective policy, practice and health professional training programs to ensure access to health care services in rural areas have eluded even the most economic and technologically advanced societies.

IV. IMPACT ON HEALTH

As stated earlier, health is a positive concept emphasizing social and personal resources lived by people in the settings of their everyday lives. In the rural context, attaining optimal health capacity is a challenge for the individual in isolation of adequate levels of supportive medical, social and financial resources. These same resources, however, may be relatively easy to access in more urban locations. Developing and optimizing scarce social and personal resources in rural areas requires creative responses and an approach more integrated in nature.

In "What it Takes: Structuring Interagency Partnerships to Connect Children and Families with Comprehensive Services"[6], the author discusses how policy and practice have failed our children in a number of ways including the following system problems:

- Most services are crisis-oriented
- The current social welfare system (in America) divides the problems of children and families into rigid and distinct categories that fail to reflect their interrelated causes and solutions
- There is a lack of functional communication between the system and the needs of children and their families.

Thus, we cannot depend upon the traditional health system to improve the "health" or well-being of rural populations. While it is a critical component of a system of services, traditional health services are crisis-oriented and "fixative". That is, providers are taught to simply fix physical and emotional problems. Health services historically provide bandages but fail to respond to the underlying causes of the trauma. It is only when root problems are addressed in the community setting that the health system becomes truly curative. (See Figure 4) Sutures applied to the eye of an abused child is fixative and a quick fix at best. While there are times when fixative care is appropriate, policy does not support comprehensive solutions to complex problems when they are indicated.

In her work, Primary Care, Concept, Evaluation and Policy"[7], Barbara Starfield evaluates 10 industrialized countries based on a number of factors designed to assess the relative success of policy and practice in meeting the needs of people for primary care services. In her analysis only two in ten countries rank as "good" in terms of their ability to comprehensively respond to the peoples health needs. The balance rank poor to moderate or variable.

Consistently, those countries ranking poor in terms of comprehensiveness of primary care services also rank poor or moderate in terms of their health systems having a community orientation.

Systems must work through communities to organize services to improve the health status of the population. This entails the reduction of barriers to necessary services in favor of a comprehensive approach to delivery which mobilizes various community-based resources, not only to resolve immediate problems but to improve the social and environmental impacts on individual "health". This, then is the new definition of primary care and the implied direction for policy, practice and education.

In the rural context, an integrated and comprehensive health service delivery system is particularly critical because, as mentioned earlier, there are fewer resources and less support for additional resource development.

V. COMPONENTS OF HEALTHY HEALTH SYSTEMS

A viable and appropriate health system encourages the health of the people it serves as described above. The system is designed with this goal in the forefront. It measures its success by doing those things necessary to reduce the population's reliance on it for fixative measures. Traditional payment policies for health services have not embraced these concepts. However, they have dramatically affected the practice of medicine and in turn the design of training programs for health professionals.

Fee-for-service as well as cost-based and prospective payment system (Including Diagnosis Related Groups, DRGs) reimbursement strategies have provided inappropriate incentives for health service delivery. (See Table 1)

Most policy development and strategies have encouraged over-utilization as well as rapid development of specialty and tertiary fixative services provided by individual providers or large corporate or bureaucratic organizations which meet their financial expectations through goals and objectives supporting increased health service utilization. Some strategies have provided decreased utilization incentives and decreased specialization incentives. Other strategies, such as capitation (per person or member capped payments) and budgeting transfer the financial risk for service provision to the provider. Unfortunately, few strategies have served to create incentives for integrated services responsible for ensuring the health of the population. Only capitation provides somewhat of an incentive to address the "health " of the populace. However, corporate capitation strategies can be accused of limiting access to necessary services to ensure short term profit-making. In summary, financing policies alone do not ensure an appropriately responsive health system. Nor do financing strategies ensure that the "health" needs of the individual or family are being met, even if there is an adequate supply of services available. Who then can be accountable for the health of the public?

A healthy system of services responds to the needs of its clients through creative community development activities. (See Figure 5) Policy, especially financing policy, drives both practice and health professional education. It makes no sense to attempt to resolve inequities in health resource distribution or health status improvement, if policy supports the opposite goals of tertiary services and fixative care. Encouraging the development of integrated local resources in support of healthy people should be the focus of policy development. Financing strategies should include the following system development perspectives:

A. Person Development:

A challenge for teaching institutions and teachers is to develop programs supporting locally "grown" and trained primary health care professionals. This direction holds promise for improving health system responsiveness to meet the rural needs at a number of levels. At one level, in order to increase the likelihood of trained health professionals remaining in the community, programmatic development should be designed to minimize time away from the community. At another level, non-locally developed health care providers may not begin to understand the cultural or ethnic perspectives that influence health. Except in the most frontier of places, financing policy must insist on building from the ground up. It should reduce the dependency of rural communities on external providers as they may ultimately be a drain on resources that might otherwise be available to the community for service delivery. In fact, external providers may never be in a position

within the community to respond effectively to individual or cultural problems or conditions.

B. Changing Perceptions of Quality and Capability

Because of historical deficits in rural service delivery, there is a perception that small places do not have the potential to deliver high quality services or develop comprehensive systems for people. There is a problem in changing this perspective because of a lack of policy advocacy. Another way for pedagogical pursuits to build rural infrastructure is to establish rural and frontier communities as interdisciplinary training centers. This is not only possible, but desirable, because as mentioned earlier, bigger is not better in health care. Health is a personal thing. Affecting the health of the individual is a complex task, often requiring a variety of specific strategies to enhance the capacity of the person.

In terms of practice, the community is the optimal level to develop integrated health systems. It is the place where people affected by health care policy decisions reside. Whereas in the past, it might be assumed that rural communities did not possess the capability to perform complex or high-technology tasks, technology and expertise is readily available through computer and other communications innovations and these can be designed to meet specific community needs.

C. Establishing a Strong Health Promotion, Illness Prevention Component

Health policy must provide incentives to educate individuals about things which they must do to maintain and improve their own health as well as the overall functioning of the community. When health systems benefit because they are accountable for health of the population served, then we will see the health of people improve.

In addition, systems must be accountable for the prevention of illness and be able to muster necessary resources that support this direction. Therefore, medical practice must expand its view to assist in the identification of factors which add to poor health and have access to a broad range of services to respond to individual conditions.

Teaching institutions support this perspective when they alter curricula to reinforce that the individual provider exists in a community of other providers and is therefore part of a potential system of services available to people.

D. Maintaining a Primary Care focus

Why primary care? Primary care services, in the broad sense, should encourage the use of interdisciplinary health care teams to meet the health needs of the individual. At a minimum, these health teams include social workers, family therapists, case managers and mental health professionals in addition to primary care physicians, mid-level and allied health service providers.

Primary care is predicated on early interventions to reduce the occurrence or progress of disease. These providers are the first contact that individuals have when entering the system.

As discussed earlier, financing policy has provided incentives to health service providers to provide more frequent, more intense or specialized services and to keep people in the fixative system longer. The measures of accountability for abuse of these incentives, such as utilization review are punitive in nature. Future policy directions should reward systems for early interventions as well as preventive service delivery to reduce health care costs while improving the health status of the population. This is particularly critical in rural areas where resources are already inadequate to meet the fixative health needs of the population.

E. Developing Appropriate Non-Community-Based Relationships

Since rural areas are dependent on urban partners for many specialty services, it is important that healthy relationships exist between them. This is best obtained from the perspective of grass-roots or bottom-up relationships for referral and support services. In competitive market models, the question should be; "Which urban or specialty provider(s) will provide our local health system the best service?". The policy perspective is often; "What do we have to do to meet the minimum needs of the rural population?". The former enhances the position of the rural health system. The latter, a dependency approach to assuring minimum care.

VI. HEALTHIER COMMUNITIES

Healthy communities are often defined in terms of the relative wealth of the people within them. Since rural agrarian and post-industrial communities do not possess the per capita financial resources of their urban counterparts, there is a perception that they cannot respond effectively to the needs of the populace. Healthier communities however, are better defined as those that enter into a conscious process to solve problems at a number of levels. (See Figure 6)

A. Developing Local Capacity

The famous American author Samuel Clemens (Mark Twain) once said that "The only real change happens locally". This is why the community should be an active participant in health systems planning and development processes. These processes should include providers of services and well as consumers. The goal of these processes should be to integrate service delivery programs and maximize limited resources in support of the health of the population.

To the extent that health services exist in the private sector, community efforts to create responsive and accountable health systems should move ownership into the hands of the community. To the degree that services are publicly owned, structures need to be established that hold bureaucracies accountable at the community level, not only for the services provided, but for the health of the population.

B. Inter-agency, Intra-community development

While community-based ownership issues are invaluable to the establishment of accountable health systems, community development activities involving a broad representation of the community are critical in terms of "Increasing responsiveness and accountability between systems and institutions located in the community, and internally between the leadership and constituency within each system serving a community".[8] Thus, communities must actively engage their health systems in an attempt to assure responsiveness to local needs. It is the dynamic interaction between community and systems needs that have the greatest potential for solving access problems and improving individual health.

C. Cultural Responsiveness

Even the most well-intentioned service delivery systems, if not integrally part of the local community, will fall short of responding the health needs of the population. Policy supporting healthier communities ensures active participation and ownership of the health system that is broadly representative of a full range of cultural and ethnic groups within the community. "First, possible leaders must be chosen and trained in community skills such as finance and administration. Only when the communities regain identity and motivation will the organization of community health become possible".[9] Remember that policy should support health systems working through communities to improve the health of the target population. Communities are defined by the characteristics of the people within them.

VII. CONCLUSION: ROLES OF POLICY, PRACTICE AND PEDAGOGY IN RURAL HEALTH IMPROVEMENTS

A. Health Policy

Health care financing policy must provide incentives for health services to shift from fixative to curative and preventive models of delivery. These models are not sustainable within a purely medical practice or teaching environment. The shift must be made to financing health in the broad social context.

Policy makers must pay for primary care practice including the various disciplines that support the full range of health needs of the individual including physical, emotional and social. Payment systems must support the training of primary health care teams and begin to blur the lines between providers to meet people's needs. Within the context of finite budgeting policy-makers must choose primary care over specialty services.

Neither corporate structure nor centralized bureaucracy are capable of meeting a rural range of rural health needs. Policy must mandate local control and decision-making. There needs to be a shift in policy thinking movers towards empowering communities. Rural inhabitants are survivors and fully capable of solving problems given adequate resources and permission.

B. Support Systems

Urban providers have a role in supporting the needs of rural areas for health services. Urban practices or systems can be partners through providing assurances to rural systems including:

- Technical Assistance

  Urban systems, educational institutions and governmental agencies can offer rural areas various levels of technical assistance to assist them in sustaining an appropriate levels of services including: systems development, practice management, financing strategies, organizational development, technology transfers, etc.

  In addition, depending on the size and nature of the rural community, it is impossible to provides a full range of services to the population. Strong referral and follow-up relationships are necessary to meet the full range of needs of the individual. Urban partners are indispensable in this regard. The paradigm shift occurs when the decisions on what and who to refer to come from the community.

  Urban health systems and teaching institutions can provide manpower to relieve the burden of service provision in remote areas. This is important to prevent rural provider burnout and turnover. Support can come in the form of locum tenens services, tele-communications relationships, site visits and case support, etc.

- Pedagogical Support/Teaching Institutions Responses

  The shift in training must emphasize resource expenditures on primary care training. Primary care faculty must be raised in terms of their status within teaching institutions. They are after all the genesis of most referrals into the tertiary system. In addition, training must move from urban tertiary centers to rural-based experiences. These experiences must be interdisciplinary in nature as health teams become the basis for ensuring better health in the population.

C. Community Development

Rural service integration is critical to providing access to a full range of health services sustainable by the community. This will require substantial local effort and policy support as services are often entrenched in categorical organizational structures. These systems should be developed, owned and operated by the community.

In addition, if the ultimate goal of service provision is to improve the health of the population as well as ensure equitable access, financial incentives in the system must reflect this. Since large corporations or organzations have not responded effectively to these particular priorities, communities must develop as the point of accountability for improving the health of the population.

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TABLE 1: Payment Structures

	Payment Structure Incentives in Health Care			
	Frequency	Intensity	Duration	Accountability
Fee-for-Svc	High	High	High	Utilization Review
Cost Reim	High	High	High	Utilization Review
DRGs	High	High Low*		Utilization Mngmt
Capitation	Low	Low	Low	U.M./Health Status
Budgets	Low	Low	Low	Utilization Control

* = While keeping hospital stays short, DRGs have created a substantive non-hospital based delivery system, also adding to increased health care costs.

Figure 1: Areas of Consideration for Rural Health

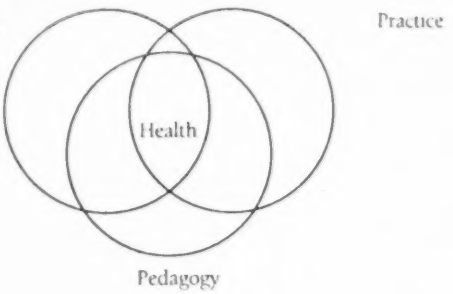

Figure 2: Shifting Perspectives

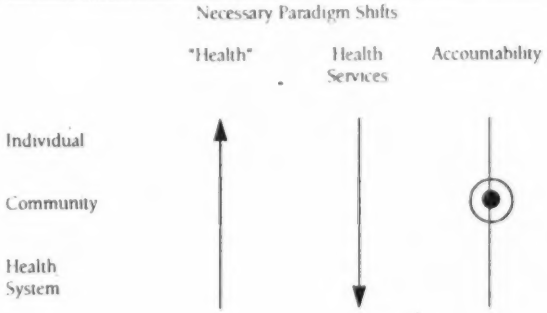

Figure 3: Fragmentation & Resource Drain